For Public Release

Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation

Health Care Payment Learning and Action Network

Synthesis of Breakout Group Input from the March 25, 2015 Kickoff Meeting

May 14, 2015

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1. Introduction

On March 25, 2015, the White House hosted the kickoff meeting of the Health Care Payment Learning and Action Network (the "Network"), featuring opening remarks by President Obama, Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell, and Dr. Patrick Conway, Acting Principal Deputy Administrator and Chief Medical Officer at the Centers for Medicare & Medicaid Services (CMS). Secretary Burwell reiterated the goal of moving 30 percent of all Medicare payments into alternative payment models (APM), such as Accountable Care Organizations (ACO), bundled payments, and patient-centered medical homes (PCMH), by 2016 and 50 percent by 2018. She emphasized that stakeholder participation is critical to achieving the Network's goal of increasing the adoption of alternative payment models that improve quality and reduce costs. President Obama was the keynote speaker, describing how a central goal of the Administration's health policy efforts is making health care affordable, and rewarding the value rather than the volume of care.

Participants included chief executive officers and senior leaders from the health care community, as well as providers, payers, employers, patients, consumer groups, health experts, and state and federal government agencies. Participants represented a wide variety of interests: publicly traded companies, non-profit organizations, urban facilities, rural providers, small practices, large systems, and national associations. Some 200 participants gathered at HHS headquarters for the afternoon discussions to begin identifying the most important next steps to achieve the Network's goals.

CMS contracted with the CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research and Development Center (FFRDC) operator, The MITRE Corporation (MITRE), to independently convene and manage the Network. MITRE, a not-for-profit chartered to work in the public interest, operates FFRDCs for the federal government and serves as an objective, independent advisor to CMS and other HHS operating divisions.

1.1 Synthesis Purpose and Use

At the Department's request, MITRE prepared this independent synthesis of the kickoff meeting's breakout group discussions and participant comments. This document summarizes the primary topics and organizes key themes from the responses to six questions. The topics and themes presented here reflect the participants' most common opinions and recommendations. The goal of this synthesis is to promote transparency and inform stakeholders of topics of interest for Network action. While this document captures the scope of the kickoff proceedings, detailed recommendations and next steps are not a part of the synthesis; they will be documented separately after input from and discussions with the Guiding Committee Co-Chairs, Guiding Committee members, and CMS. Ultimately, the full synthesis will provide the foundation for and inform the Network's next steps.

The comments supplied in this synthesis are intended to capture the participants' ideas as closely as possible to their own words. The comments do not represent verbatim statements and were not validated with the participants. This synthesis does not reflect an Administration position on the comments or concepts included in the synthesis. Appendix A contains a high-level bulleted list of the most common responses to the six questions.

For more information on the Network, please visit http://innovation.cms.gov/initiatives/health-care-payment-learning-and-action-network/.

1.2 Network Kickoff Meeting

During the Network kickoff meeting, both President Obama and Secretary Burwell emphasized the importance of moving toward value-based payment, and aligning incentives that promote better care delivery and improved patient outcomes. HHS recognizes aligning health care payment requires a collaborative effort, and seeks to work with partners in the private, public, and non-profit sectors to promote national goals beyond Medicare. As health care transitions from the conventional Fee-for-Service (FFS) volume-based model to APMs, the Department created the Network as a forum for stakeholders to discuss how to implement and support new payment models and overcome barriers to adoption. Through the Network, HHS will emphasize value over volume, and make progress toward the shared goals of a better, smarter, and healthier system: one that delivers better care, spends our dollars more wisely, and helps keep our citizens healthier.

Dr. Patrick Conway expressed the vision for health system transformation, and established the day's goals of eliciting discussion and ideas while building on the existing collaboration necessary to achieve system-wide improvements and reforms across private, public, and nonprofit sectors. Next, Dr. Meena Sheshamani, Director of the HHS Office of Health Reform, facilitated a panel of six presenters who discussed how their respective organizations were working to transform the nation's health care system. The panel members were providers, payers, purchasers, consumer associations, and states. Each presenter described their organization-specific goals for APMs; barriers that their organizations have successfully overcome; and the overall importance of moving to APMs.

The participants formed breakout groups for the afternoon session. The groups represented a variety of stakeholders, including consumers, purchasers/employers, states, payers, and providers. With HHS staff facilitating the sessions, each breakout group answered two assigned questions.

Breakout Group Questions for Stakeholder Response

Question A: What are the key areas for alignment that will make participation in alternative payment models more efficient? What aspects of alternative payment models are best for alignment? (Responses might include attribution, benchmarking, reporting requirements, shared decision-making.) What are the most important early wins for the Network (that we can accomplish in the first year)?

Question B: What are the most important factors required for alternative payment models to deliver better quality at lower cost? (Responses might include technical assistance to providers, data sharing with providers, steady phasing-in of risk sharing, patient engagement.)

Question C: How should the Learning and Action Network structure the way it works to address national issues vs. regional/local issues associated with alternative payment models? What best practices are likely to remain consistent nationally and what practices are likely to differ based on region? (Responses might outline topics that vary from national to regional and which aspects of the topics should be handled nationally or regionally. What regional entities can facilitate progress on these topics?)

Question D: What can you and your organization do to drive progress towards the national goals? Participants can comment on activities of their own organization as illustrations for others.

Question E: What are your best ideas for sustaining momentum of Learning and Action Network activities over the first 6 months; the first 12 months; the first 18 months?

Question F: What can the Learning and Action Network do for your organization? What is the value proposition of the Learning and Action Network for the participants?

The goal of the breakout groups was to clarify ideas and explore the recommended priorities of Network participants.

Section 2 presents the independent synthesis and summary of the thoughts shared in the breakout groups based on the meeting notes, flipchart lists, and informal polling results.

2. Summary of Participant Input: Network Focus Areas and Network Operations

The topics and themes summarized here reflect the participants' most common opinions and recommendations. Since the goal of this synthesis is to promote transparency and inform stakeholders of topics of interest for Network action, the following subsections do *not* represent decisions or next steps for the Network.

The breakout group discussions addressed two primary categories: (1) focus areas to accelerate adoption of APMs and (2) recommendations for operating the Network. The operational recommendations identify the necessary process steps to establish and develop a successful Learning and Action Network. This categorization of the topics may be helpful to the Network when considering future focus areas and while creating processes to implement Network activities.

2.1 Network Focus Areas to Accelerate Adoption of APMs

The breakout groups cited several topics as key factors for APM growth and success that need the Network's attention. These topics require focused efforts to secure greater alignment within and among the key stakeholder groups. This subsection provides the topics, with descriptions and predominant conversation points within the breakout group discussions.

2.1.1 Measurement Challenges

Participants suggested better alignment of both quality and cost measures. They pointed out the challenges stakeholders face with the current inconsistency of quality measures and their specifications.

2.1.1.1 Quality Measures

Participants expressed frustration by the number of quality measures, varied measure specifications, reporting burden, and their perceived inability to compare measure results. Participants focused on reducing the reporting burden for providers and ensuring that measure information allows for comparisons and benchmarking at the local, regional, and national levels as important items. Participants emphasized that measures must be meaningful to consumers and support clinical decision making. Participants suggested the need for clear definitions in the context of quality measurement. They recommended identifying a core set of measures with universal specifications for use within APMs. They also suggested allowing for optional measures, including specialty measures that meet needs at the regional or local level. Some participants wanted to see more emphasis on outcome measures; all wanted to simplify the current state and improve efficiency in quality measurement.

Participants expressed a need for actionable, accurate, timely, risk-adjusted performance measures to enable practice transformation. Quality measures should include amenability to internal quality improvement. At present, the health care system invests many resources to track and report the number of quality measures and specification variations of the "same" measures. Agreement on identical quality measures would allow valid comparisons and a common understanding of quality and value by payers, providers, and consumers alike.

Participant Comments

- **Need for Measure Alignment:**
  - Quality measurement is a key area. Having different organizations with different quality measures makes providers insane. Achieving as much alignment as possible across programs and payers is critical. (State)
  - Providers have so many different measures. Payers say measures are the same, but the specifications are slightly different, which causes the measure to be different. (Provider)
- **Recommendations for an APM Core Measure Set:**
  - Alignment work needs to be at both the national and state levels. The federal government cannot impose on states—states will not accept. Our consumer group participated in a multi-stakeholder group that came up with the idea of having core measure sets; states or regions could then add supplemental sets. Organizations could accept core measures and test experimental measures at the local level. (Consumer)
  - Our paradigm has been building the best measures and letting people pick, but we ended up with a giant number of measures. There should be a core set of measures. Specifications should be very detailed and granular for comparative alignment. (Consumer)
- **Align with Clinical Relevance:**
  - We need to assess whether metrics are getting at policy goals and align with financial incentives. We must ensure the clinical relevance of quality measures. (Purchaser)
- **Complement other Measure Alignment Activities Currently Underway – Avoid Redundancy:**
  - Several initiatives are underway for quality measure alignment outside the Network. I am worried about derailing progress of the Network if we focus on quality measure alignment. (Payer)

2.1.1.2 Cost Measures

The participants recommended implementing cost measures that are transparent, have consistent specifications, and are tied to the overall program goals.

Participant Comments

- **Results-oriented Cost Measurement:**
  - Performance transparency should include quality as well as total cost of care metrics. People need to know what to expect and to understand their own performance. Everyone needs to be aligned. (Payer)
  - The core set of measures that drive financial reward are key—it is what counts in the end and motivates the clinical practice groups (100+ groups have reported this). We need alignment at least around the outcome measures—how will you measure quality and how will you measure cost? What is it we are trying to improve to gain rewards, and how is total medical cost measured? (Payer)

2.1.2 Alternative Payment Model Definitions

The breakout groups expressed the need to have common definitions for APM terms. Establishing common definitions between and across stakeholders is essential. Various technical terms—such as APM, capitation, bundle, patient-centered medical home (PCMH), and population—do not have consistent interpretations, and consumers do not understand the terms. Some participants believe that common definitions set a foundation for a productive dialogue about the benefits of APMs and ways to accelerate their adoption. Definitions may help align the attributes of APMs and develop common features of a new payment paradigm. The definitions should promote national alignment while allowing regional flexibility to tailor models. Participants shared the belief that the Network can produce definitions, and this would help support alignment efforts of stakeholder organizations and improve consumer and patient engagement.

Participant Comments

- **Need for Definitions:**
  - Definitions are important. People say, "If you've seen one ACO, then you've seen one ACO". Many people have slightly different definitions of how ACOs work, and how providers are paid. The same is true for PCMHs, bundled payments, and other APMs. If the Network can produce definitions and agree on what these things are, that would be helpful for other organizations to come together. Definitions of APM, governance, and population, as well as definitions of bundles themselves, are needed. (Health Expert)
  - If the Network can use consensus to define APMs, it will provide direction and be a helpful mechanism to achieve the goals. We want to make the definition understandable. There are thousands of definitions of bundles—we need concrete guidance within the definitions. (Provider)
- **Translation for Consumers and Patients:**
  - Building from the definitions, we also need to focus on "translation"—how do we translate the definition into something that makes sense to the patient and consumer? We need to consider how the definition promotes meaningful engagement and education so patients can ask questions of their provider. Also, we need to have the patient understand enough to choose their APM. Often the definitions we set may be aimed at sophisticated stakeholders. For example, how do we translate a term like ACO into a patient-friendly term and make it understandable to patients and families? This translation will facilitate better relationships between providers and patients in these models. We need patients to stay within the model/system to make any of this work. Translation applies to most areas on the list, not just definitions. (Patient/Consumer)

2.1.3 Financial Approach and Incentives

Several of the breakout groups discussed the need to align financial incentives among stakeholders. The participants acknowledged the current challenge of conflicting incentives for providers—pay for volume versus pay for value. Participants stated that stable, well-defined, transparent, and predictable APM methodologies must be in place and developed in

collaboration with all stakeholders. Well-developed business cases for moving into APMs would be extremely helpful to providers. APMs should also recognize the upfront costs for the delivery system to transform. Several participants favored alignment of payment incentives between providers and payers. Payment incentives and levels of risk must be considered together to move providers toward risk acceptance.

Participant Comments

- **Financial Incentives**
  - This has to be about the financial side of payment; aligning incentives is important because there are conflicting incentives. Capitation goes a long way in aligning incentives. (Provider)
  - Providers should be paid for keeping people out of the emergency department and taking calls at night, etc. If they are not making a sufficient profit, they will not do this. (Payer)
  - To transform workflow, we need a larger reward from providers. All need to agree on the goals, and it needs to be well funded prospectively! These are complete workflow changes for an office. Primary care physicians (PCP) do not have the capital to cover them. (Provider)
- **Financial Risk:**
  - We need alignment of financial incentives for providers to take on risk. Benchmarks should align with the degree of risk to assure providers invest sufficient financial resources to offset their risks. Providers need ways to learn to manage the risk. (Provider)
- **Investment:**
  - We need to recognize that there is an investment and not a quick return on savings—do not hobble initiatives with unreasonable expectations. (Provider)
  - Providers must have some long-term predictability—not just short term. Predictability is necessary for investment. (Payer)

2.1.4 Data Reporting and Sharing

Participants raised the topics of data reporting, standardization, and data sharing in multiple contexts during many breakout group discussions. While the term "data" was not always defined during the dialogue, the types of data referenced included administrative, encounter, cost, quality/performance, comparative, clinical, behavioral health, and consumer data. Participants pointed out the difficulty of utilizing data that is not uniformly reported or comparable. Some participants emphasized the need to use data for accountability, benchmarking, quality improvement, risk stratification, and transparency purposes; others were concerned about meeting the information needs of clinicians, payers, and individual patients. Several participants stated that the current data sharing and interoperability capabilities of payers and clinicians are not sufficient to allow adequate management of the quality and cost of care under new APMs. The participants frequently mentioned the challenges associated with reporting and sharing "like" data and their desire to use various types of data within the context of APMs.

2.1.4.1 Reporting Simplification

The participants discussed the current administrative demands and the need for streamlining and reducing the burden of reporting. Simplification would also help enable data sharing between and among providers, payers, and patients.

Participant Comments

- **Data Collection and Reporting:**
  - We need to align data collection of quality measures across providers and align the definition of an episode across payers. We also need to consider the impact of administrative burden on small practices. (Provider)

2.1.4.2 Data Use

Participants suggested improving access to actionable, accurate, usable, secure, risk-adjusted data, and having the right data at the right time. This will make it easy for providers to react to and use data.

Participant Comments

- **Access to Timely Meaningful Data:**
  - We need to have rapid-fire results to know what is working to achieve consumer buy-in for the new payment models and do course correction. (Consumer)
  - With respect to data, even the people sharing performance and cost data do not really know what is in there or what story it tells about their practice. There needs to be alignment on what is legitimate data aimed at accountability, and what is legitimate data to use for improvement. These can be two separate purposes with different needs. We are trying to change the conversation to looking at data for insights, to get people more comfortable with sharing data. (Payer)
  - We need to think through the process for clinical performance data that supports real-time clinical decisions and makes clinicians' lives better such as reducing administrative complexities. Primary care physicians have so many reporting requirements that it gets in the way of doctor-patient relationships and may hamper efforts to address socio-economic status problems. (Provider)

2.1.4.3 Data Exchange

Participants noted the lack of alignment in the exchange of timely meaningful data. The current data exchange functionality is variable and acts as a barrier for providers and consumers in the areas of decision making and benchmarking.

Participant Comments

- **Data Sharing:**
  - We look at data exchange as not just provider to provider, but also as providers to consumers. We want patients to access their own clinical data to make informed health care decisions. (Consumer)

  - A key enabler is sharing population health data. We are hugely dependent on timely datasets so we can risk-stratify our population. We have many insurers that are interested—they want us to manage care, but will not give us data to do it, although they still want us to use their proprietary information. We need to agree on what are the sharable datasets and the right format, so we can choose the right tool and consistently share the right data. (Provider)

- **Interoperability:**
  - We need functional interoperability. In the current environment, the system cannot exchange information in a way so providers can send a referral back and forth. (Provider)

- **Database for Benchmarking:**
  - On the cost side, there is a body of knowledge around performance levels. The field requires alignment on what is an achievable level of performance, and this will be different depending on whether we are measuring a new or older system. Perhaps a national benchmarking database is needed. (Payer)
  - Data sharing with providers is needed here. When a provider gets data on their performance compared to national benchmarks or peers, they improve. (Provider)

2.1.5 Attribution

Some participants thought that addressing the complex issue of patient attribution could exhaust Network energies and leave few resources for tackling other important topics. Some participants believe alignment of patient attribution requires addressing managed care populations and specialty care issues. Patient movement in the marketplace and consumer knowledge levels should be considered. Participants identified flexibility and patient engagement as key considerations when designing patient attribution approaches.

Participant Comments

- **Scope and Categories:**
  - Patient attribution is the first key area. We have to be flexible depending on Medicare and Medicare Advantage. We need to figure out how to do attribution for the Preferred Provider Organization (PPO) population, and may need adjustments by organization type. When we started discussing this in 2008, some organizations did not want attribution to include specialty care, so we left it out. But that is an open question. Can attribution work for multi-specialty groups? Attribution with and without specialty care should be considered. (Payer)

- **Patient Engagement:**
  - We hear very clearly that for ACOs to work, we need a better patient attribution system. We cannot ask patients to answer a question that they do not understand. How can we do a better job defining attribution for patients? How do we engage the patient in defining these? We should emphasize outreach and education after definitions are set. With the marketplaces, we saw a steep consumer education ramp of what to do. To some extent, we are back to square one. We need to do outreach

and education to bring consumers to a place to make decisions. I do not think the models will work unless they work for patients. (Patient/Consumer)

- **Consistent Methods:**
  - Our attribution methods should be consistent, rational, and "good enough". There is no perfect way to attribute: we should just make sure we do not hang too much on the attribution. If there are too many financial implications associated with the attribution methodology, there could be too much focus on methodology instead of the financial implications of actual quality improvement. There also needs to be a patient view of what that attribution means—attribution implies there is a relationship. (Payer)

2.1.6 Reassessing and Simplifying Legal Barriers

Participants identified the need to potentially redesign legal barriers, such as fraud and abuse laws, as the payment incentives change from rewarding volume to rewarding value.

Participant Comments

- **Reassess Antitrust Fraud and Abuse Laws:**
  - Restrictions exist based on FFS to avoid overtreatment. These restrictions impede alignment. For example, consider the Stark law, and other fraud and abuse laws. These laws are necessary in a FFS system, but how and when can we lower or redesign these legal barriers to promote alignment and advancement of APMs? When interests are aligned, these restrictions become less important. "I do not think we are at the tipping point yet to make the transition. We need a balance with timing—providers will want these restrictions lifted too early in the process of moving to APMs." If the Network can come to consensus about how and when to adjust the barriers appropriately, this would be beneficial for everyone, including government and providers. (Provider)
  - We need protections for providers in new relationships, such as APMs, to prevent accidental legal trouble. Protections are particularly needed for legal issues like civil monetary penalties and anti-kickback liability with ACOs. (Provider)
  - In general, we need more clarity in anti-trust issues, including collusion and legal obstacles. (Purchaser)
- **Consumer Perspective on Legal Barriers:**
  - It is important to include the consumer and patient community in these conversations. We should discuss the topic of legal barriers with the consumer and patient groups rather than springing changes on patients. Oftentimes, the consumer community is running at full speed to catch up.(Consumer)

2.1.7 Underserved Populations

Several participants were concerned about underserved populations and the impact of APM implementation on vulnerable populations and rural areas. The discussion topics included the social determinants of health and low population density areas. Participants supported the importance of focusing attention on underserved populations, including racial, ethnic, rural, or

other hard-to-reach populations, as payment models are developed. Rural communities would benefit from APM simplification and support for the transition to value-based payment.

Participant Comments

- **Adjustment for Social Determinants of Health:**
  - One option is risk adjustment based on social determinants of health. The playing field needs to be leveled—not all populations are the same, but it is more than risk adjustment. (Provider)
- **Rural Challenges:**
  - We need to simplify, especially as we roll out into rural areas. Right now, it is FFS and all these things tacked on, which is too complicated. We need to get this into rural areas if we are going to hit the Secretary's goals; it cannot just be in metro areas. (Provider – rural)
- **Vulnerable Populations:**
  - How can we work in this Network to ensure that reforms will address health disparities, and not simply consider race and socio-economic status? We should look at what will actually improve health and outcomes of underserved groups. (Consumer)
  - We need to proactively identify people, reach out to them, and include them. I would start by making sure there was a work group that focuses on these kinds of racial and ethnic disparities, and maybe even including rural and other hard-to-reach populations. We need to do it in a way that we solicit real and concrete input from leaders in those communities. When trying to figure out how to deal with different populations, we need to figure out how to get the best, most relevant input. (Health IT)

2.1.8 National and Regional Roles

Participants emphasized the concept of national alignment with regional/state flexibility as an important consideration. Discussions highlighted the state or regional role versus the federal role in various policy decisions. Participants underscored the need for state flexibility and local autonomy. The tension between national uniformity and local innovation permeated many of the discussion topics.

2.1.8.1 National Standardization, Local Innovation

Participants suggested that the Network leverage local experience to guide national policy, standards, and development of common definitions. Participants also recommended using local experts to identify and harmonize with differences among regions, and assist local efforts when necessary.

Participant Comments

- **Best Practices – National Standards, Regional Benchmarking:**
  - There needs to be a national APM methodology and standard as a starting point. Local efforts should target the environment and individuals. Regionally, the approaches might follow different paths, starting from the national approach. (Purchaser)
  - Consider the national targets, goals, and measures as defining the "What", with the regional implementation as the "How". We should learn from the implementers what real change takes place at the local level. (Expert)
- **Variation and Standardization:**
  - Consistent and achievable measurement is important or providers will not even try. We need to recognize there is wide variation in health and cost at a regional level and set the proper targets. (Consumer)
  - The national health care community needs standardization without stifling innovation and regional forces. The Network should focus on a relatively small set of goals in any 2- or 3-year period, and allow the participants to decide where they need to drive improvement. (State)
  - There should be local flexibility to meet provider needs within the care continuum. Providers have varying levels of readiness for APMs and quality improvement. (Payer)

2.1.8.2 Regional Entities, Feedback, and Sharing Lessons Learned

Participants suggested that learning from and building on previous work is important when addressing national and regional/local issues associated with APMs.

Participant Comments

- **State Commissions:**
  - Almost every state has a commission working on payment reform, and they are powerful voices for what has worked or failed in the states. (Federal Agency/Payer)
- **Feedback Loop:**
  - We need a feedback loop to share best practices. If we have national policies feeding into regional and local policies, we also want to provide local and regional feedback to the national level. With a feedback loop, learning can come from local experiences. (Provider)

2.2 Network Operations

Participants offered tactical and operation-focused suggestions for launching this national, multi-stakeholder Network. The suggestions focused on the Network's goals and structure, processes and tools, engagement, and information sharing. Participants emphasized sharing information related to successes and misses, and having a highly collaborative framework to support the mission of the Network. In some discussions, participants recommended engaging additional

providers and other stakeholders more broadly to advance understanding of APMs and the direction of paying for quality not quantity.

2.2.1 Identifying Goals and Developing a Network Structure

Participants agreed a clear vision was crucial to align Network stakeholders toward achieving common goals. Participants suggested setting clear, specific, and realistic goals and objectives for the Network to generate early wins. Developing guiding principles and workgroups with appropriate expertise will facilitate greater stakeholder engagement and drive progress toward APMs. Although participants advocated for structure, they mentioned that the Network should enable, rather than over-facilitate, stakeholder participation.

Participant Comments

- We need to articulate the vision for this effort. According to Dr. John Kotter's 8-step process for leading change, we need to look for early wins, engage the coalition, establish goals, and get some momentum going. (Provider)
- The Network should be very clear on destination and aim high. (Provider)
- We have to be specific and have focused work groups with the right people at the table with the right goals. (Provider)

2.2.2 Stakeholder Engagement

Stakeholder engagement was another important topic. Participants suggested that all stakeholders should be engaged in driving progress toward national goals. Toward that end, breakout groups requested active Network engagement with stakeholders through effective messaging. Participants emphasized the need to involve consumers and patients in decision-making discussions throughout the process to promote acceptance and understanding of APMs. In addition to consumers, patients, and providers, participants identified payers, employers, health experts, and state and federal government agencies as key stakeholders.

Participants noted that providers will play an integral role in the transformation and their perspective is critical to success. Participants suggested that more provider feedback, especially from frontline providers, would help move the system to APMs and promote a better understanding of the Network's priorities. Participants also recognized it was important to integrate providers into the process of developing solutions to gain their expertise and support.

Participant Comments

- Moving to high-quality care at a lower cost needs broad stakeholder acceptance from patients, providers, and payers. If we expect a model to successfully drive improvement, it should be acceptable to all stakeholders. (Provider)
- We need systemic patient engagement at multiple levels within the APM process as well as feedback loops back to those patients. (Provider)
- Physicians prefer to be part of the decision-making process. To gain physicians' buy-in, we need to ensure that they are engaged in advance of any final solutions. (Provider)

- The Network can facilitate meaningful partnerships with consumers. We can help with both the education and outreach to consumers, and help facilitate meaningful engagement to bring families and patients to the table. (Consumer)

2.2.3 Network Collaboration and Information Sharing

Participants agreed that collaboration and dissemination of information within the Network and to the public would help achieve national goals. Participants asked to share successes and misses through a Network forum that enables discussion and learning. Participants acknowledged the importance of increasing public understanding and acceptance regarding the move toward APMs. Participants also requested frequent Network updates to assure clear communication with their own stakeholders and consumers. Several participants volunteered to assist the Network in disseminating information by running webinars, workshops, and convening stakeholders.

Participants pointed out that payers and providers separately launch APMs. The participants suggested a more efficient approach of sharing business models, manuals, risk-bearing methods, and templates. Several participants have developed resources to make their systems more efficient, and recommended using the Network as a forum to share this information. One breakout group suggested developing a database with topics of interest to better understand payment models (including gaps), promote market alignment, and help facilitate collaboration.

Participant Comments

- **Learning Forum:**
  - APMs are not a new concept for private payers. We want to learn from each other, and more specifically, about payment models and best practices for employers. (Purchaser)
  - If we focus only on successes, we will make the same mistakes as each other. We also need to share challenges and efforts that did not succeed. (Federal/Other)
  - The Network should capture the imagination of the public first. If we can get early traction and build momentum, on a few things without bogging down, then the public will come along—then the payment models will follow. (Payer)
  - We have opportunities to leverage existing resources in CMS and from others. What are shared resources and best practices? The Network should consider what CMS can share and what we can share with you. (Payer)
- **Tool Development and Sharing:**
  - We can potentially share data use agreement templates and business associate agreement templates. Sharing these is simple, and will save time and resources without having 15 lawyers draft 15 documents. This could be a quick win. (State)
  - An APM "startup manual" is a great early win. A transition manual is the other one—it is critical. Payment models are disruptive innovations, and we are doing these calculations for every new implementation. (Provider)

2.2.4 Provider Education and Training

Breakout groups suggested education and support for providers moving into APMs, such as guidebooks or templates specific to the providers' needs. Providers in the breakout groups agreed that peer-to-peer learning is a preferred approach. Several participants urged engaging rural providers in APMs and APM training. Participants said all stakeholders should consider how APMs affect different geographic regions.

Participant Comments

- Providers need education that these APMs are coming and that they need to be ready. We need to help them transition with education and support. (Provider)
- Peer-to-peer learning is the best approach. (Provider)
- As we have moved into rural communities, the knowledge level about APMs is not there. Trying to explain APMs presents a challenge for rural physician practices. If there was a startup manual with guiding principles, that would be very helpful in rural communities. (Provider)

Appendix A. Summary of Question Responses

This Appendix presents a high-level summary and quick reference list of the key ideas from the breakout group responses to the six questions (A–F). Section 2 provides the summary analysis for each question.

Breakout Group Questions for Stakeholder Response

Question A: What are the key areas for alignment that will make participation in alternative payment models more efficient? What aspects of alternative payment models are best for alignment? (Responses might include attribution, benchmarking, reporting requirements, shared decision-making.) What are the most important early wins for the Network (that we can accomplish in the first year)?

Question B: What are the most important factors required for alternative payment models to deliver better quality at lower cost? (Responses might include technical assistance to providers, data sharing with providers, steady phasing-in of risk sharing, patient engagement.)

Question C: How should the Learning and Action Network structure the way it works to address national issues vs. regional/local issues associated with alternative payment models? What best practices are likely to remain consistent nationally and what practices are likely to differ based on region? (Responses might outline topics that vary from national to regional and which aspects of the topics should be handled nationally or regionally. What regional entities can facilitate progress on these topics?)

Question D: What can you and your organization do to drive progress towards the national goals? Participants can comment on activities of their own organization as illustrations for others.

Question E: What are your best ideas for sustaining momentum of Learning and Action Network activities over the first 6 months; the first 12 months; the first 18 months?

Question F: What can the Learning and Action Network do for your organization? What is the value proposition of the Learning and Action Network for the participants?

A.1 Question A: Key Areas for Alignment to Make Participation in APMs More Efficient

- Align cost and quality measurement (process/outcome/efficiency), define core measure sets, ensure uniform measure specifications, and identify meaningful measures that are actionable for providers and informative for consumers.

- Align APM goals and identify clear, easily communicated Network guiding principles for the Network stakeholders.
- Develop clear and consistent definitions to establish a common understanding of APM technical terms and promote operational alignment across all stakeholders.
- Align financial approaches and incentives; consider provider risk acceptance, realistic payment goals, and goal-based incentives; and incorporate APM business case development and financial predictability approaches for use by smaller providers who cannot finance upfront APM costs.
- Facilitate the alignment of data reporting and data sharing (with interoperable systems, timely data availability, and secure processes) between and among stakeholders. Promote data utilization for clinical decision-making, accountability, and improvement purposes.
- Align approaches to patient attribution that can be commonly used without investing large resources into this issue for every new APM model type and setting.
- Align key APM messaging. Outreach, education, and information translation for patients and consumers is important and promote transparency.
- Assess ways to reduce administrative burden for providers, especially with reporting/regulatory processes.
- Consider how to address the social determinants of health and identify potential risk adjustments for socio-economic status.

A.2 Question B: Most Important Factors for APMs

- Promote access to accurate and reliable data that is adequate to measure outcomes; standardization of data; functional data interoperability with provider accountability for participation.
- Promote availability of adequate and realistic business cases for providers.
- Provide operational and payment transition support as providers move from FFS to APMs; consider promoting prospective payment.
- Agree on common goals and achievement of critical mass alignment.
- Recognize the need for a phased-in approach with flexibility to assist physicians and organizations in different stages of development.
- Engage consumers and stakeholders; facilitate transparency.

A.3 Question C: Recommendations for Network Support of Learning / Sharing

- Incorporate local experiences and feedback to direct national policies; establish a national framework for improving alignment.
- Engender and grow communication across all stakeholder groups; encourage greater provider/patient and provider/payer interaction and communication. Employ effective and appropriate messaging to stakeholder groups; communicate APM value added.

- Engage and incorporate feedback of stakeholders, especially consumers and providers; employ stakeholder feedback loops throughout APM development and implementation. Capture and share case studies, lessons learned, and best practices, including what is not working; connect and integrate with other like initiatives; leverage successful initiatives.
- Facilitate peer-to-peer and bi-directional learning, with operational/tactical/practical focus; learn from the early adopters; acknowledge differing levels of provider readiness.
- Focus special attention on vulnerable populations and rural, low-density community needs.

A.4 Question D: Offers – How Participants Can Help

- Share lessons learned, and provide a forum for stakeholder groups, e.g., webinars, workshops, and networks, to share information.
- Build partnerships with stakeholders at the community, provider, and consumer level, and provide education and training to bring awareness and engagement, especially with providers.
- Develop and share tools to improve system efficiency; collect and share data to better understand the current landscape; and join the measure alignment efforts.
- Assist in identifying the models that are working, and provide input on model development.

A.5 Question E: Sustaining Momentum and Early Wins (First Year)

- Focus on patients in all payment and policy decisions to ensure the focus and energy of all stakeholders.
- Set specific, realistic, focused goals and communicate a clear vision to accomplish early wins.
- Engage with stakeholders at all levels to garner feedback about setting Network priorities and goals, developing solutions, and providing education and tools.
- Establish effective communication, transparency, and collaboration; share lessons learned and leverage experience from others; and communicate success stories to keep the public informed of progress.

A.6 Question F: Network Success Factors – How Can the Network Help Participants?

- Articulate a clear vision, guiding principles, and common, realistic goals.
- Share lessons learned (both successes and misses) to create a base of information and gain a better understanding of the models.
- Establish alignment across sectors and collaboration among stakeholders.
- Provide standardization of definitions and measures so organizations can effectively assess performance; ensure these measures are flexible for different organization types.

A.7 Cross-cutting Themes

- Recognize the need to balance between national uniformity and local innovation; create national standardization with built in state flexibility and local autonomy.
- Develop targeted interventions and payment models for special populations, and/or special categories of need, such as rural and low-density communities, communities with health disparities, pediatric population, mental/behavioral health, and dental health.
- Address the provider challenges as FFS transitions to APMs; providers will have difficulty maintaining FFS operations while transforming practice and operations to APMs.

Acronyms

ACO	Accountable Care Organization
APM	Alternative Payment Model
CAMH	CMS Alliance to Modernize Healthcare
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
FFRDC	Federally Funded Research and Development Center
FFS	Fee-for-Service
GPRO	Group Practice Reporting Option
HCPLAN	Health Care Payment Learning and Action Network
HHS	Department of Health and Human Services
PCMH	Patient-Centered Medical Home
PCP	Primary Care Physician
PPO	Preferred Provider Organization
PQRS	Physician Quality Reporting System